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ABSTRACT

This revised digest presents basic information on mental retardation for educators and others. First, definitions from the Individuals with Disabilities Education Act (IDEA) and the American Association on Mental Retardation (AAMR) are presented. The fact sheet then analyzes how the new AAMR definition differs from earlier ones noting the new definition's emphasis on a pattern of limitations and on a multidimensional approach to assessment. The AAMR use of the term "supports," is also explained noting the eight types of function that support can serve and four levels of support intensity. Also cited are figures showing the number of children, aged 6-21, who were classified as having mental retardation and received services under IDEA. Additional paragraphs list typical characteristics of children with mental retardation and consider educational implications (such as use of more hands-on instructional materials with these children and short but frequent learning sessions). The fact sheet also lists 10 suggested additional readings, 9 organizational resources, and 3 periodicals. (DB)

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MENTAL RETARDATION

Charlotte Hawkins-Shepard

What is mental retardation?

A definition for mental retardation is found in Public Law 101-476, the Individuals with Disabilities Education Act (IDEA) of 1990:

> *Mental retardation* means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance.
> [*Federal Register*, 57(189), September 29, 1992, p.44801]

In its 1992 manual on definition and classification, the American Association on Mental Retardation (AAMR) offers the following definition:

> *Mental retardation* refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: Communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18.

Significantly subaverage intellectual functioning means an IQ score of 70 to 75 or below on a standardized individual intelligence test. *Related limitations* refers to adaptive skill limitations that are related more to functional applications than other circumstances such as cultural diversity or sensory impairment.

How does the new AAMR definition differ from earlier ones?

The 1992 AAMR definition represents a significant change in the way those with mental retardation are viewed. Rather than describing mental retardation as a state of global incompetence, the new definition refers to a pattern of limitations, looking at how people function in various contexts of everyday life. This definition is based on four assumptions: (1) Valid assessment considers cultural and linguistic diversity, as well as differences in communication and behavioral factors; (2) The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for support; (3) Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities; (4) With appropriate supports over a sustained period, the life functioning of the person with mental retardation generally will improve.

Rather than limiting assessment to intellectual and adaptive skills, the current AAMR definition relies upon a multidimensional approach to describing individuals and evaluating their responses to present growth, environmental changes, educational activities, and therapeutic interventions:

Dimension I:	Intellectual functioning and adaptive skills
Dimension II:	Psychological/emotional considerations
Dimension III:	Physical/health/etiological considerations
Dimension IV:	Environmental considerations

What does the term *supports* mean?

The concept of supports, as described by AAMR, refers to certain resources and strategies provided to persons with mental retardation that enhance their independence/interdependence, productivity, community integration, and satisfaction. These supports can come from technology, individuals, and agencies or service providers. Supports can be grouped into eight types of function: (1) befriending, (2) financial planning, (3) employee assistance, (4) behavioral support, (5) in-home living assistance, (6) community access and use, (7) health assistance, (8) teaching (Schalock et al., 1994).

The AAMR concept of supports includes assigning one of four levels of intensity to each support: (1) intermittent, or "as needed," which are seen as short-term supports, such as during an acute medical crisis; (2) limited, which are those supports needed regularly, but for a short period of time, such as employee assistance to remediate a job-related skill deficit; (3) extensive, seen as ongoing and regular, such as long-term home living support; (4) pervasive, viewed as constant and potentially life-sustaining, such as attendant care, skilled medical care, or help with taking medications.

The current AAMR definition involves a three-step procedure for diagnosing, classifying, and determining the needed supports of an individual with mental retardation: (1) determine eligibility for supports (IQ 70-75 or below, significant disabilities in two or more adaptive skill areas, age of onset below 18); (2) identify strengths and weaknesses and the need for support across the four dimensions—intellectual functioning and adaptive skills; psychological/emotional considerations; physical/health/etiological considerations; and environmental considerations; (3) identify the kind and intensities of supports needed for each of the four dimensions.

How many children have mental retardation?

According to the U.S. Department of Education (*Fifteenth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*, 1993, p. A 60) during the school year 1991-92, 554,247 children aged 6-21 were classified as having mental retardation and receiving educational services under IDEA, Part B, and Chapter 1 of the Elementary & Secondary Education Act (ESEA), State Operated Programs. Individual state reports for the 1991-92 school year indicated variations in the number of these students from a total of 436 (Alaska) and 625 (Wyoming) to 32,660 (Pennsylvania) and 41,933 (Ohio).

What are some typical characteristics of children with mental retardation?

Among individuals with mental retardation, there is a wide range of abilities, disabilities, strengths, and needs for support. It is common to find language delay and motor development significantly below norms of peers who do not have mental retardation. More seriously affected children will experience delays in such areas of motor-skill development as mobility, body image, and control of body actions. Compared to their nondisabled peers, children with mental retardation may generally be below norms in height and weight, may

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experience more speech problems, and may have a higher incidence of vision and hearing impairment.

In contrast to their classmates, students with mental retardation often have problems with attention, perception, memory, problem-solving, and logical thought. They are slower in learning how to learn and find it harder to apply what they have learned to new situations or problems. Some professionals explain these patterns by asserting that children with mental retardation have qualitatively different deficits in cognition or memory. Others believe that persons with mental retardation move through the same stages of development as those without retardation, although at a slower rate, reaching lower levels of functioning overall.

Many persons with retardation are affected only minimally, and will function only somewhat slower than average in learning new skills and information.

What are some educational implications?

For younger children with mental retardation and persons with more extensive limitations in their adaptive skills, teachers may find that hands-on materials are more meaningful than pictures and demonstrations more instructive than verbal directions. Teachers should build on students' existing skills by teaching easier tasks before more complex tasks; breaking longer, new tasks into small steps; and prompting or shaping accurate performance. Teachers should help students develop rules and provide opportunities for them to apply or transfer what they have learned. They can help students generalize by using multiple examples and settings.

It will help students with mental retardation if shorter and distributed (not massed) learning sessions are provided in the instructional process, especially school, living, community, and work environments. From an early age, life skills including daily living, personal/social skills, and occupational awareness and exploration should be taught. Instruction in leisure and recreational opportunities and skills also should be a part of the educational program along with vocational preparation and training for adult living. As much as possible, children and youth with mental retardation should be educated inclusively: in schools, classrooms, and activities with their nondisabled peers.

Additional Readings

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Schalock, R. L., Stark, J. A., Snell, M. E., Coulter, D. L., Polloway, E. A., Luckasson, R., Reiss, S., & Spitalnik, D. M. (1994). The changing conception of mental retardation: Implications for the field. *Mental Retardation, 32*, 181-193.

Resources

American Association on Mental Retardation (AAMR)
444 North Capitol St., NW, Suite 846
Washington, DC 20001
(202) 387-1968; toll free: (800) 424-3688; fax: (202) 387-2193

The Arc
500 E. Border St., Suite 300
Arlington, TX 76010
(817) 261-6003; TTY: (817) 277-0553; fax: (817) 277-3941

The Association for Persons with Severe Handicaps (TASH)
11201 Greenwood Ave. N.
Seattle, WA 98133
(206) 361-8870

Division on Mental Retardation & Developmental Disabilities
The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091-1589
(703) 620-3660

National Down Syndrome Congress
1605 Chantilly Dr., Suite 250
Atlanta, GA 30324
(800) 232-NDSC

National Down Syndrome Society
666 Broadway
New York, NY 10012
(212) 460-9330; toll free: (800) 221-4602

President's Committee on Mental Retardation (PCMR)
U. S. Department of Health & Human Services
330 Independence Ave., SW
Washington, DC 20201
(202) 619-0634

People First International (self-advocacy group)
1340 Chemeketa St., NE
Salem, OR 97301
(503) 588-5288

Special Olympics International, Inc.
1350 New York Ave., NW, Suite 500
Washington, DC 20005
(202) 628-3630

Periodicals

American Journal on Mental Retardation
Mental Retardation
American Association on Mental Retardation
444 No. Capitol St., NW, Suite 846
Washington, DC 20001

Education and Training in Mental Retardation and Developmental Disabilities
Division on Mental Retardation & Developmental Disabilities
The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091-1589

Journal of the Association for Persons with Severe Handicaps
Division on Mental Retardation & Developmental Disabilities
The Council for Exceptional Children
1920 Association Drive
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